

Urology Associates of San Luis Obispo Patient Registration for Minors

Please print

Patient's name: _____
Last First M.I.

Address: _____ Home Phone: _____
 City: _____ State: _____ Zip: _____ Social Security (required) _____

Sex: M/F _____ Age: _____ Birth date _____

Parent/Guardian/Guarantor Relationship to Patient _____

Name (Last, First, MI): _____ Phone _____

Address: _____
Street City State Zip

Who has legal custody? _____

Is custody shared? _____ If yes, by who _____
Y/N

Employed by _____ Address _____

Occupation _____ Bus. phone _____ Cell phone _____

Second Parent/Guardian Relationship to Patient _____

Name (Last, First, MI): _____ Phone _____

Address: _____
Street City State Zip

Employed by _____ Address _____

Occupation _____ Bus. phone _____ Cell phone _____

Referred by _____

Primary Care Physician _____

INSURANCE INFORMATION

<p><u>Primary Insurance</u></p> <p>Name of Carrier _____</p> <p>Street Address _____</p> <p>City, State, Zip _____</p> <p>Insurance ID No. _____</p> <p>Group # _____</p> <p>Subscriber _____</p> <p style="margin-left: 40px;">Relationship to patient _____</p> <p style="margin-left: 40px;">Subscriber Birth date _____</p> <p>Employers Insurance Plan <u>Yes/No</u></p>	<p><u>Secondary Insurance</u></p> <p>Name of Carrier _____</p> <p>Street Address _____</p> <p>City, State, Zip _____</p> <p>Insurance ID No. _____</p> <p>Group # _____</p> <p>Subscriber _____</p> <p style="margin-left: 40px;">Relationship to patient _____</p> <p style="margin-left: 40px;">Subscriber Birth date _____</p> <p>Employers Insurance Plan <u>Yes/No</u></p>
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I ACKNOWLEDGE THAT PAYMENT IS DUE ON RECEIPT OF STATEMENT FOR SERVICES RENDERED. I AGREE TO PAY A LATE PAYMENT CHARGE OF 1% PER MONTH ON THE UNPAID BALANCE OF MY ACCOUNT THAT IS DELINQUENT 60 DAYS OR MORE. IF MY ACCOUNT IS REFERRED TO COLLECTION, I ALSO AGREE TO PAY REASONABLE ATTORNEY'S FEES AND COLLECTION EXPENSES.

PARENT/GUARDIAN/GUARANTOR SIGNATURE

 Date